

# ACFS LLC

Adult, Child & Family Services, LLC  
1400 Madison Ave, Suite 610, Mankato, MN 56001 - 507-387-3777

## Employment Application

ACFS is an EEO/Affirmative Action Employer committed to excellence through diversity. Employment offers are made on the basis of qualifications, and without regard to race, sex, religion, national or ethnic origin, disability, age, veteran status, or sexual orientation.

PLEASE PRINT. Complete the entire application. Attach your resume and complete all questions or your application will be deemed incomplete and may not be considered.

### NAME and ADDRESS

Name (First, MI, Last)	Social Security Number
Mailing Address	City, State, Zip Code
Telephone Number	Email Address

### Job Type

Position of Interest:	
<input type="checkbox"/> Outpatient Therapist	<input type="checkbox"/> MH Practitioner (ARMHS)
<input type="checkbox"/> Administrative	<input type="checkbox"/> MH Practitioner (CTSS)
<input type="checkbox"/> Internship	

### Day/Hours Available to Work

<input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday <input type="checkbox"/> Saturday <input type="checkbox"/> Sunday	
<input type="checkbox"/> Full-Time Employment <input type="checkbox"/> 3/4 Time Employment <input type="checkbox"/> 1/2 Time Employment	
How many hours can you work weekly?	
Can you work evenings?	
Date available to start?	

### Additional Information

Have you ever been employed by ACFS in the past? <input type="checkbox"/> yes <input type="checkbox"/> no	
Have you ever received mental health services by ACFS? <input type="checkbox"/> yes <input type="checkbox"/> no	
I certify that I am a U.S. citizens, permanent resident, or a foreign national with authorization to work in the United States. I will provide the required document, as requested. <input type="checkbox"/> yes <input type="checkbox"/> no	
Have you ever been investigated, charged or are currently being investigated with harm, neglect, or abuse to a child or an adult? If so, what were the results? <input type="checkbox"/> yes <input type="checkbox"/> no	
Results:	
Do you have a Minnesota Driver's License? <input type="checkbox"/> yes <input type="checkbox"/> no	
Have you had any motor vehicle accident during the past three (3) years? <input type="checkbox"/> yes <input type="checkbox"/> no	
How did you hear about this employment opportunity? _____	

### Education

Name of School:	
High School	Graduated? <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/>
GED	<input type="checkbox"/> yes <input type="checkbox"/> no
College/University/Community or Trade School	Graduated? <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/>

	Major:
	Degree:
College/University/Community or Trade School	Graduated? <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/>
	Major:
	Degree:
College/University/Community or Trade School	Graduated? <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/>
	Major:
	Degree:
<b>Work Experience</b>	
Please list ALL work experience beginning with the most job. Attach additional sheets, if necessary.	
Company #1	Supervisor Name
Dates of Employment	Supervisor Phone Number
Job Title	Final Wage
Reason for leaving:	May we contact this employer? <input type="checkbox"/> yes <input type="checkbox"/> no
<hr/>	
Company #2	Supervisor Name
Dates of Employment	Supervisor Phone Number
Job Title	Final Wage
Reason for leaving:	May we contact this employer? <input type="checkbox"/> yes <input type="checkbox"/> no
<hr/>	
Company #3	Supervisor Name
Dates of Employment	Supervisor Phone Number
Job Title	Final Wage
Reason for leaving:	May we contact this employer? <input type="checkbox"/> yes <input type="checkbox"/> no
<hr/>	
<b>References</b>	
Please include name, phone number and relationship to reference.	
1	
2	
3	
<hr/>	
<b>Disclosure Questions</b>	
Completed by Only Outpatient Therapist Candidates	
1. Has your professional license or registration ever been terminated, stipulated, restricted, limited, conditioned, suspended, revoked, refused, voluntarily relinquished or not renewed by any licensing board or any health -related agency organization, or is there a review pending? <input type="checkbox"/> yes <input type="checkbox"/> no	
2. Has your professional license or registration ever been investigated or is it currently being investigated or is it currently being investigated and, if so, what were the results? <input type="checkbox"/> yes <input type="checkbox"/> no	
3. Has your membership, participation, clinical privileges or employment ever been denied terminated, stipulated, restricted, refused, limited, suspended, revoked, or not renewed by any peer review organization, third party payer, clinic, hospital, medical staff, or any health related agency	

or organization, or is there a review pending?  yes  no

4. Have you ever voluntarily relinquished your membership, participation, clinical privileges or request for privileges employment, professional license, or registration in lieu of disciplinary action, or prior to or during an investigation into your professional conduct or competency?  yes  no

5. Has your membership or fellowship in any professional organization or your speciality board certification ever been voluntarily or involuntarily denied, terminated, restricted, limited, suspended, or revoked?  yes  no

6. Have you ever been reprimanded, censored, or otherwise disciplined by, or have you ever been subject to a corrective action agreement/plan with any licensing board, peer review organization, third party payer, clinic, hospital, medical staff, or any health-related agency or organization?  yes  no

7. Has your certificate or participation in any private, federal or state health insurance program ever been revoked or otherwise limited or restricted, or is any investigation or proceeding with respect to any such action presently underway?  yes  no

8. Are there any charges pending or are you currently charged with or have you ever been indicted or found guilty of a felony, gross misdemeanor, misdemeanor, or other offense?  yes  no

9. Have you ever been found liable, guilty, or responsible for sexual impropriety or misconduct or sexual harassment with a patient/client, co-workers, or other?  yes  no

10. Have you ever had any professional liability claims or lawsuits brought against you, including pending claims or lawsuits, dismissed or dropped claims, or lawsuits, settlements, or final judgments?  yes  no

11. Has your professional liability carrier ever refused or canceled your coverage or excluded you from performing any specific privileges within your speciality?  yes  no

12. Have you ever practiced within your profession without professional liability insurance?  yes  no

13. Do you have a physical or mental condition that would affect your ability, with or without reasonable accommodation, to provide appropriate care to patients/clients and otherwise perform the essential function of a practitioner in your area of practice without posing a health or safety risk to your patients/clients?  yes  no If yes, what accommodations would help you provide care:

14. Does your use (or have you been told that your use) of alcohol or drugs affect your ability, with or without reasonable accommodation, to provide appropriate care to patients/clients and otherwise perform the essential function in your area of practice without posing a health risk to your patients/clients?  yes  no If yes, what accommodations would help you provide appropriate care?

#### Disclosure Questions

Completed by Only ARMHS Mental Health Practitioners

In order to be considered for the position, you must be qualified in one of the following ways:

1. A mental health professional and who holds a current and valid national certification as a certified rehabilitation counselor or certified psychosocial rehab practitioner.

2. A mental health practitioner who works under the clinical supervision of a MH Professional.

3. A certified peer specialist who can work under the clinical supervisor of a MH Professional.

4. A mental health rehab worker who works under the direction of a MH practitioner or MH professional and under the clinical supervision of a MH professional.

Meets one of the following qualifications:

1. Has a AA degree or two years FT post-secondary education in one of the behavioral sciences or human services, is a registered nurse without a BA or who within the previous ten (10) years has three (3) years of life experience as a primary caregiver to an adult with a serious mental illness or traumatic brain injury or 4,000 hours of supervised paid work experience in the delivery of MH services to adults with a serious mental illness or traumatic brain injury.

2. Is fluent in a non-English language in the culture of the ethnic group to which at least 20% of the assigned caseload, receives clinical supervision for the first 2,000 hours of work, has 18 hours of documented field supervision during the first 160 hours of contact work and at least six hour of field supervision on a quarterly basis, has review and consignment of charting of recipient contacts during field supervision and has 15 hours of CEU's during the first year of employment.

Disclosure Questions Completed by Only CTSS Mental Health Practitioners

In order to be considered for the position, you must be qualified in one of the following ways:

1. Holds a bachelor's degree in a behavioral science/related field, from an accredited college AND meet either A. or B.

A. Has at least 2000 hours of supervised experience in the delivery of mental health services

B. Is fluent in the non-english language of the cultural group in which at least 50% of the practitioners recipients, completes, 40 hours of training in the delivery of services, and receives clinical supervisor from a mental health professional at least once a week until the requirement of 2,000 hours is met.

OR

2. Has at least 6000 hours of supervised experience in the delivery of mental health services. Hours worked as a mental health behavioroal aid 1 or 2 may be included in the 6000 hours of experience for recipients.

OR

3. Is a graduate student in one of the mental health professional disciplines and is formally assigned by an accredited college to an agency or facility for clinical training.

OR

4. Holds a masters or other graduate degree in one of the mental health professional disciplines from an accredited college.

License/Certification

License/Cerification

Date Issues

Date Expire

Issued by/Location of issuing authority

License number

License/Cerification

Date Issues

Date Expire

Issued by/Location of issuing authority

License number

License/Cerification

Date Issues

Date Expire

Issued by/Location of issuing authority

License number

**Other Credentials/Licenses/Professional Affiliations:**

Please list any other credentials, licenses, professional affiliations, etc., which are relevant to the job for which you are applying:

**Skills**

Please list any technical skills, clerical skills, trade skills, etc., relevant to the position. Include relevant computer systems, and software packages of which you have a working knowledge and note your level of proficiency, (basic, intermediate, or expert).

**Cover Letter**

All applicants are required to submit a cover letter, no longer than three (3) pages addressing:

1. State your purpose for pursuing the position of interest.
2. Describe the personal qualities and professionally related experiences that qualify you.
3. Describe your theoretical orientation to counseling (OP therapist, Interns only)
4. Provide information on your experience in working with individual from diverse backgrounds and your commitment to understanding diversity.
5. Provide an overview of your ability to use technology.

I certify that the information provided and its supporting document are accurate. I understand that any misrepresentation or omission of facts, represents grounds for elimination from consideration for employment, or termination. I authorize ACFS to investigate, without liability, all statements contained in the application and support materials. I authorize references and former employers, without liability, to make full response to any inquiries in connection with application. I agree to submit to a physical exam, criminal and credit background investigation, and/or screening for illegal substances upon a conditional offer of employment, if requested. This document DOES NOT indicate an offer of employment. I understand that the employees of ACFS are considered At-Will. I will also comply with all required employment documentation required by ACFS.

Applicant Signature:

Date:

**APPLICATION REQUIREMENTS:**

Employment Application

Cover Letter

Resume or Vita

Copies of all college/university transcripts

Copy of diploma from highest degree obtained

Copy of current licenses and/or credentials

Proof of substantiated hours of supervised experience w/ mental illness (MN Practitioner)

Vehicle Insurance Card (CTSS & ARHMS)

**POST HIRE REQUIREMENTS:**

W-4

